STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175558	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Leawood - Iron Horse Hlth	5401 W 143rd Street Leawood, KS 66224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. The facility identified a census of 64 residents. The sample included 16 residents, with two reviewed for reasonable accommodation of needs related to assistive devices. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 51 had a way to communicate her needs due to her call light being left out of reach. This deficient practice placed the R51 at risk for preventable accidents and injuries. Findings Included:- The Medical Diagnosis section within R51's Electronic Medical Records (EMR) included diagnoses of muscle weakness, overactive bladder, need for assistance with personal care, history of falling, and cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R51's Quarterly Minimum Data Set (MDS) completed 04/08/25 noted a Brief Interview for Mental Status (BIMS) score of six, indicating mild cognitive impairment. The MDS noted she required substantial to maximal assistance for transfer, bathing, toileting, bed mobility, dressing, and personal hygiene. The MDS noted she had no falls. R51's Fall Care Area Assessment (CAA) completed 04/07/25 indicated she was at risk for a decline in her activities of daily living (ADL) related to her medical diagnoses. The CAA noted she will work with therapy services on strength training and provide interventions to minimize the risk related to her decline in ADL and potential falls. R51's Care Plan initiated on 02/25/25 indicated she was at risk for falls and a deficit of her ADLs related to her medical diagnoses. The plan indicated she required substantial to maximal assistance from staff for transfers, toileting, bathing, personal hygiene, dressing, and bed mobility. The plan noted she had a history of falls and instructed staff to ensure her call light was within reach. The plan instructed staff to ensure she had a Dycem (a nonslip mat placed to prevent sliding in her wheelchair and maintain a clear path in her room. The plan noted she required two staff members for transfer assistance. The plan instructed staff to ensure her call light remained within reach while in her room. On 08/04/25 at 07:05 AM, R51 slept in her bed. R51's soft-touch call light was located on top of her bedside table. R51's bedside table was across the room next to her recliner and out of her reach. On 08/04/25 at 08:15 AM, R51 remained asleep in her bed. R51's soft-touch call light remained on her bedside table next to her recliner. On 08/06/25 at 12:23 PM, Certified Nurse's Aide (CNA) M stated call lights were to be placed within reach or clipped onto the resident's clothing. On 08/06/25 at 12:45 PM, Licensed Nurse (LN) G stated staff were expected to ensure the call light remained within reach during each interaction. On 08/06/25 at 01:04 PM, Administrative Nurse D stated staff were expected to check the call light placement each shift and ensure the residents had access to the lights if they needed assistance. The facility's Fall Management System dated 06/2018 indicated the facility promoted an environment that remains free from accident hazards. The policy indicated that the facility assessed and provided the appropriate equipment to ensure resident safety. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility identified a census of 64 residents. The sample included 16 residents, with two residents reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide a final summary of the resident's status at discharge for Resident (R) 6. This deficient practice placed R6 at risk of delayed care or uncommunicated care needs.Findings included:- R6's Electronic Medical Records (EMR) documented diagnoses infection and inflammatory reaction due to internal right knee prosthesis (an artificial body part), Methicillin-Resistant Staphylococcus Aureus (MRSA- a type of bacteria resistant to many antibiotics), pain, need for assistance with personal care, age related cognitive decline (related to the mental process), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dysphagia (swallowing difficulty). R6's Admissions Minimum Data Set (MDS) completed 07/13/25 noted a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented she had an impairment of her lower extremity. The MDS documented R6 needed setup or cleanup assistance with eating and oral hygiene. The MDS documented R6 was dependent on staff for toileting.R6's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA), dated 07/13/25, documented R6 had a reduction in activities of daily living (ADL), and she needed increased staff assistance with ADLs, which included transfers, bed mobility, toileting, and hygiene. The CAA documented R6 continued with skilled services to regain strength and return to the highest functioning level. R6's goal was to return home. The CAA for R6 documented the risk factors, including further ADL decline, falls, incontinence, skin breakdown, and pain. The care plan would be initiated and reviewed to improve or maintain current ADL status and functional ability, maintain or improve continence status, decrease pain, decrease falls, and pressure ulcer risk.R6's EMR recorded a Discharge Assessment-Return Not Anticipated MDS documenting R6's discharge date d 07/14/25.R6's Care Plan, revised 08/01/25, documented that the facility would establish a pre-discharge plan with R6 and her family and caregivers, and evaluate progress and revise the plan as needed.R6's EMR under Progress Notes revealed a Nursing Note completed on 07/14/25, documenting R6's husband was in the facility, stated he was going to pack R6's belongings, and take her home. Nursing explained to R6's guardian the facility was waiting for labs for her wound. R6's guardian stated he was taking R6 home. Nursing called the physician to inform him of R6's discharge from the facility.R6's medical record lacked documentation showing recompilation of her stay in the facility.On 08/06/25 at 12:39 PM, Licensed Nurse (LN) I stated it was the responsibility of the nurse in charge on the day the resident was discharged to do a summary of the resident's stay. She stated this would include how the facility cared for the resident, medications, and follow-up appointments.On 08/06/25 at 01:13 PM, Administrative Nurse D stated it was the charge nurse's duty to ensure a recompilation of stay was documented. She stated if the charge nurse did not document the resident's stay, it was the director of nursing's responsibility.The facility's Discharge policy dated 05/17 documented it was the policy of this facility to set forth the circumstances and conditions under which the facility could require the resident to be involuntarily transferred, discharged , or evicted.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. The facility identified a census of 64 residents. The sample included 16 residents, with 16 reviewed for care planning. Based on observation, record review, and interviews, the facility failed to identify the level of care assistance needed for activities of daily living (ADL) on Resident (R) 54's care plan. This deficient practice placed R54 at risk for ineffective treatment and preventable accidents.Findings Included: - The Medical Diagnosis section within R54's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), need for assistance with personal care, muscle weakness, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R54's Quarterly Minimum Data Set (MDS) completed 01/07/25 noted a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted no upper or lower extremity impairments. The MDS noted she required partial to moderate assistance for lower body dressing, footwear, bathing, toileting, and oral hygiene. The MDS noted she required supervision or touch assistance with upper body dressing, personal hygiene, bed mobility, and walking. R54's Functional Abilities Care Area Assessment (CAA) completed 06/16/25 indicated she needed assistance from staff for her ADLs and self-care related to her medical diagnoses. R54's Care Plan initiated on 11/15/24 indicated she was at risk for an ADL deficit related to her medical diagnoses. The plan noted she would maintain her current level of function in bed mobility, transfers, eating, dressing, grooming, toileting, and personal hygiene. The plan noted she preferred assistance with personal hygiene and instructed staff to wash her hair with her showers. The plan lacked documentation showing R54's level of functioning and the required level of assistance needed to complete bathing, transfers, dressing, oral hygiene, meals, and bed mobility. On 08/04/25 at 08:05 AM, R54 walked from the hallway to the dining area with her walker. R54 sat down at the dining room table and prepared herself for breakfast. R54 reported no issues or concerns related to her care. R54 was clean and well-groomed. On 08/06/25 at 12:23 PM, Certified Nurse's Aide (CNA) M stated the care plans needed to include the resident's current level of functioning and assistance needed. She stated the Kardex should also include this information. On 08/06/25 at 12:45 PM, Licensed Nurse (LN) G stated care plans were updated to reflect each resident's level of functioning and assistance needed. On 08/06/25 at 01:04 PM, Administrative Nurse D stated the care plan should identify each resident's required level of functioning and assistance needed. She stated that the interdisciplinary team meets each week to review the plans and update them with changes. The facility's Comprehensive Person-Centered Planning policy, revised 08/2017, indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.

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	175558	A. Building B. Wing	08/06/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. The facility identified a census of 64 residents. The sample included 16 residents, with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to ensure the physician's order was followed for a daily weight for R5 to monitor for congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). This deficient practice placed R5 at risk of delayed treatment and untreated illness.Findings included:- R5's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of overactive bladder, pain, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), cellulitis (a common bacterial infection of the skin and underlying tissues) of right lower limb, lack of coordination, communication deficit, need for assistance with personal car, closed fracture with routine healing, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).The admission Minimum Data Set (MDS) dated 07/15/25 documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R5 had received diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. R5's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/18/25 documented a licensed nurse would monitor for adverse effects of R5's medication every shift.R5's Care Plan, dated 07/18/25, documented nursing staff would administer medications as ordered. The plan of care documented the nursing staff would monitor for side effects and document the effectiveness.R5‘s EMR under the Orders tab revealed the following physician orders: Lasix (diuretic) oral tablet 20 milligram (mg) (Furosemide) give one tablet by mouth one time a day every Tuesday, Thursday, and Saturday for edema, dated 07/09/25.Daily weight for the next three days, dated 07/09/25. Weekly weights every seven days, dated 07/09/25.Review of R5's July 2025 Medication Administration Record (MAR), Treatment Administration Record (TAR), and the Weights/Vital Signs tab lacked evidence of documentation of daily weights for 07/10/25, 07/11/25, and 07/12/25. R5's EMR also lacked evidence of weekly weights for 07/17/25 and 07/31/25. On 08/05/25 at 02:12 PM, R5 sat on her wheelchair in her room, as she listened to her book on her tablet. R5 stated she walked 75 feet with therapy.On 08/06/25 at 12:14 PM, Certified Nurse Aide (CNA) M stated everyone worked to obtain the resident's weights as ordered. CNA M stated the charge nurse would let the staff know every day which residents needed to be weighed that day. CNA M stated she would let the charge nurse know the weight after she obtained the weight.On 08/06/25 at 12:40 PM, Licensed Nurse (LN) I stated the nurse was the person responsible to ensure a physician's order was followed. LN I stated if the physician had ordered a resident to be weighed daily or weekly that order would be placed on the MAR or TAR to prompt the nurse to ensure the weight was obtained and documented in the resident's EMR. On 08/06/25 at 01:14 PM, Administrative Nurse D stated the charge nurse was responsible for ensuring the physician's orders were followed. Administrative Nurse D stated the physician order for daily or weekly weights would be placed on the MAR or TAR to prompt the nurse to obtain the weight as ordered. The facility's Quality of Care policy, revised on 01/25/25, documented based on comprehensive assessments. The facility would ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices.

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	175558	A. Building B. Wing	08/06/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The sample included 16 residents, with five residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure-reducing devices were in place for Resident (R) 12, who was at risk for the development of pressure ulcers. This deficient practice placed R12 at risk for complications related to skin breakdown.Findings included:- R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of difficulty walking, dementia (a progressive mental disorder characterized by failing memory and confusion), lack of coordination, muscle weakness, and need for assistance with personal care.The admission Minimum Data Set (MDS) dated 04/22/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R12 was at risk for the development of pressure-related injuries. The Quarterly MDS dated [DATE] documented a BIMS score of 10, which indicated moderately impaired cognition. The MDS documented that R12 was at risk for the development of pressure-related injuries.R12's Pressure Ulcer Care Area Assessment (CAA), dated 05/10/25, documented he was at risk for the development of pressure ulcers related to his incontinence and impaired mobility. R12's Care Plan, dated 04/16/25, documented R12 required monitoring, reminding, and assistance for turning and repositioning.R12's EMR under the Orders tab revealed the following physician orders: Cushion to wheelchair, dated 06/05/25.On 08/04/25 at 12:06 PM, R12 laid on his bed. R12's wheelchair was next to the bed and lacked a cushion. R12 stated he used the wheelchair frequently.On 08/05/25 at 01:58 PM, R12 laid on his bed with the wheelchair next to the bed. R12's wheelchair lacked a cushion, and no cushion was seen in the room.On 08/06/25 at 12:14 PM, Certified Nurse Aide (CNA) M stated the therapy department would do staff education for each resident on any pressure-reducing devices for any new resident. CNA M stated it was everyone's responsibility to ensure any pressure-reducing devices for all the residents were in place. CNA M stated the pressure-reducing devices should be listed on the resident's individualized care plan or on their Kardex (a nursing tool that gives a brief overview of the care needs of each resident). CNA M stated she was not sure if every resident who was in a wheelchair required a pressure-reducing device on the chair.On 08/06/25 at 12:40 PM, Licensed Nurse (LN) I stated the nurse would be the person who would be responsible for ensuring pressure-reducing devices were in place. LN I stated everyone was to assist with ensuring pressure-reducing services were in place. LN I stated that every resident who used a wheelchair for mobility should have a pressure-reducing device. LN I stated the resident's pressure-reducing devices should be listed on the resident's individualized care plan or on their Kardex. On 08/06/25 at 01:14 PM, Administrative Nurse D stated that all staff were responsible for ensuring the resident's pressure-reducing devices were in place. Administrative Nurse D stated she would expect the resident's pressure-reducing devices to be listed on their care plans.The facility's Pressure Injury Prevention policy, last revised on 03/2022, documented the purpose of the policy was to provide for early detection and intervention of all breakdowns evident upon admission to the facility. To maintain the integrity of the residents' skin, a significant factor in health. To minimize the risks and prevent the occurrence of skin breakdown. To promote prompt evaluation and intervention of any changes in skin integrity during the facility stay. For individuals restricted to a chair was to use pressure-reducing devices for seating surfaces.

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	175558	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	175558	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility identified a census of 64 residents. The sample included 16, with three reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area and out of reach of eight cognitively impaired, independently mobile residents. The facility additionally failed to ensure Resident (R) 29's fall interventions were implemented. This placed the affected residents at risk for preventable accidents.Findings Included: - On 08/04/25 at 07:10 AM, an initial walkthrough of the facility was completed. An inspection of the Hallbrook unit revealed an unsecured soiled utility closet. An inspection of the closet revealed a bottle of solution under the sink. The bottle contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed.An inspection of the Hallbrook unit revealed an unsecured medical supply storage closet. An inspection of the closet revealed numerous medicated supplies. The bottles contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed. An inspection of the Hallbrook unit revealed purple sanitary wipes left unsecured on the counter of the nurse's station. The container contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed. An inspection of the Bridgewood unit revealed an unsecured soiled utility closet. An inspection of the closet revealed a bottle of solution under the sink. The bottle contained the warning, Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed. On 08/06/25 at 12:23 PM, Certified Nurse's Aide (CNA) M Certified Nurse's Aide (CNA) QQ stated cleaning products should be kept locked up when not being used or supervised. On 08/06/25 at 12:45 PM, Licensed Nurse (LN) G stated that cleaning wipes and bottles were to be locked up in the utility closet and away from the residents. On 08/06/25 at 01:04 PM, Administrative Nurse D stated that staff were expected to lock up the cleaning chemicals when not in use. The facility's Chemical Storage policy, revised 03/2016, indicated the facility would ensure an environment free from potentially hazardous materials, chemicals, and equipment.- The Medical Diagnosis section within R29's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), cognitive communication disorder (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), need for assistance with personal care, muscle weakness, and history of falls. R29's Quarterly Minimum Data Set (MDS) completed 06/26/25 noted a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS indicated she had no upper or lower extremity impairments. The MDS noted she required supervision or touch assistance during toileting, bathing, dressing, bed mobility, transfers, and walking. The MDS indicated she had no falls since her last assessment. R29's Fall Care Area Assessment (CAA) completed 03/20/25 indicated she was at risk for falls related to her recent increase in assistance for her activities of daily living (ADL), muscle weakness, and cognitive impairment. The CAA noted care-planned interventions were implemented to minimize the risks associated with falls. R29's Care Plan initiated on 03/10/25 indicated she was at risk for falls related to her medical diagnoses. The plan indicated she required staff assistance for personal hygiene, bed mobility, transfers, meal setup, bathing, and toileting. The plan instructed staff to ensure her call light was within reach and to encourage her to use it. The plan instructed staff to keep needed items within reach and avoid rearranging her room's furniture. The plan noted she had a non-injury fall on 07/23/25. On 07/23/25, R29's plan added a call before you fall sign posted at her bedside to prevent further falls. On 08/04/25 at 09:20 AM, R29 sat in her recliner and ate her breakfast. She stated she had a recent fall due to her attempting to take herself to the restroom. She stated she fell backwards onto the bed as she attempted to stand up. An inspection of R29's bed and room revealed no signage posted to call staff. R29 reported she's never seen signs in her room alerting her to call staff. On 08/04/25 at 11:50 AM, R29 sat in her room and watched television. An inspection of her room revealed no signage posted to alert staff to call them for assistance. On 08/06/25 at 12:23 PM, Certified Nurse's Aide (CNA) M stated R29's signage should be posted next to her bed in a visible area. On 08/06/25 at 12:45 PM, Licensed Nurse (LN) G indicated the call before you fall signs were posted next to the bed to prevent residents from attempting to self-transfer. She stated staff were expected to ensure the signage was in place and remind the residents to call for assistance. On 08/06/25 at 01:04 PM, Administrative Nurse D stated the signs were placed with bright colors next to the bed to encourage residents to call before attempting to transfer or complete their own ADLs. She stated staff were expected to ensure the signage was in place each shift. The facility's Fall Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175558	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The sample included 15 residents, with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 3's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask was stored in a sanitary manner. This placed R3 at an increased risk for respiratory infection and complications. Findings included:- R3's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN- elevated blood pressure), benign prostatic hyperplasia (urinary frequency, urgency, a weak or intermittent stream, needing to strain, a sense of incomplete emptying, and nocturia (frequent urination at night), acquired absence of right leg below the knee, acquired absence of left leg below the knee, peripheral vascular disease (a circulatory disorder where narrowed or blocked blood vessels reduce blood flow to the limbs, affection the arms, hands and limbs), colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body), communication deficit, muscle weakness, need for assistance with personal care, unsteadiness on feet, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R3 needed setup and clean-up assistance from staff for eating and oral care. The MDS documented R3 was dependent on staff for toileting and showers, and needed substantial/maximal assistance with dressing.R3's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 03/29/25 documented R3 had a reduction in activities of daily living (ADL); he needs increased staff assistance with ADLs, including transfers, bed mobility, toileting, and hygiene. Staff assist with ADLs and encourage guests to fully participate.R3's Care Plan dated 02/17/23 documented R3 had a risk for alteration in comfort, and staff were to monitor and report any signs to nursing. R3's care plan lacked an indication for a nebulizer and the storage of a nebulizer mask.R3‘s EMR under the Orders tab revealed the following physician order:Ipratropium-Albuterol solution 0.5-2.5 milligram (mg) per 3milliliters (ml), inhale orally three times a day for wheezing, dated 07/31/25.On 08/04/25 at 08:23 AM, R3 sat in his room, and his nebulizer mask was sitting on his bedside table. The nebulizer mask was not stored in a sanitary manner.On 08/04/25 at 01:18 PM, he sat in his room talking on his phone. R3's nebulizer mask laid on his bedside table. R3's nebulizer mask was not stored in a sanitary manner.On 08/06/25 at 12:14 PM, Certified Nurse's Aide (CNA) M stated the nebulizer mask was rinsed, air dried, and then placed in a bag with the date on the bag.On 08/06/25 at 12:39 PM, Licensed Nurse (LN) I stated that nebulizer masks were washed and placed in a plastic bag. LN I stated that anyone from nursing can put the mask in a bag to store when not in use.On 08/06/25 at 01:13 PM, Administrative Nurse D stated nebulizer masks were to be placed in a plastic bag with the date on the bag. She stated nebulizer mask should not be left on the bedside table.The facility did not provide a policy for the storage of a nebulizer mask.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175558	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility had a census of 64 residents. The sample included 14 residents. Five Certified Nurse Aides (CNA) were reviewed for yearly performance evaluations and in-service training. Based on record review and interview, the facility failed to ensure one of the five reviewed CNA staff had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - Review of the facility's performance evaluation and in-service records revealed the following: CNA N, hired on 10/11/23, had no yearly performance evaluations provided upon request. On 08/06/25 at 12:15 PM, Administrative Nurse D stated the facility did not have the required yearly performance evaluations for CNA N. She stated that yearly performance evaluations were completed annually for all CNA staff. The facility's Staff Requirement policy 07/2010 indicated performance reviews will be conducted on each employee at least annually to identify employee strengths and goals. The policy noted the evaluation will be utilized to determine training needs for the employee.

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	175558	A. Building B. Wing	08/06/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility reported a census of 64 residents. The facility identified two medication carts and two treatment carts. Based on observations, record review, and interviews, the facility failed to secure its two treatment carts. This deficient practice placed the residents at risk for unnecessary medication and administration errors.Findings Included-- On 08/04/25 at 07:00 AM, an initial walkthrough of the facility was completed. An inspection of the Hallbrook unit revealed an unlocked treatment cart in the back nurses' station. An inspection of the cart revealed medical ointments and wound cleansers. An inspection of the Bridgewood unit revealed an unlocked treatment cart in the hallway. An inspection of the cart revealed medical ointments and wound cleansers. On 08/05/25 at 01:23 PM, an inspection of the medication storage room on the Hallbrook unit was completed. An inspection of the medication storage refrigerator revealed two vials of tuberculin serum. One vial was opened and lacked dates related to its opening and expiration. The second vial was opened on 05/30/25 and had passed the 30-day expiration date. On 08/06/25 at 12:45 PM, Licensed Nurse (LN) G stated the treatment carts were to be locked when not in use. On 08/06/25 at 01:04 PM, Administrative Nurse D staff were expected to secure the carts and patient information when stepping away from the carts. The facility's Medication Access and Storage policy, revised 10/2023, indicated the facility was to ensure all medications and biologicals remained locked and secured to prevent tampering or exposure to the environment.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 64 residents. The sample included 16 residents. Based on observation, record review, and interviews, the facility failed to ensure physician-ordered laboratory test results for Resident (R) 42, R5, and R75 were included in the clinical record. This deficient practice could result in unnecessary tests and delayed treatment.Findings included:- R5's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Overactive bladder, pain, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), cellulitis (a common bacterial infection of the skin and underlying tissues) of right lower limb, lack of coordination, communication deficit, need for assistance with personal car, closed fracture with routine healing, and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness.The admission Minimum Data Set (MDS) dated 07/15/25 documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R5 had received diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. R5's Psychotropic Drug Use Care Area Assessment (CAA) dated 07/18/25 documented a licensed nurse would monitor for adverse effects of R5's medication every shift.R5's Care Plan, dated 07/17/25, documented a complete blood count (CBC- laboratory blood test) and complete metabolic panel (CMP- laboratory blood test) would be obtained weekly. R5's EMR under the Orders tab revealed the following physician orders:CBC and CMP weekly, dated 07/09/25. Review of R5's clinical record lacked evidence of the results of the physician-ordered laboratory tests. The facility was not able to provide a copy of the results dated 07/16/25 and 07/30/25.On 08/05/2025 at 02:12 PM, R5 sat on her wheelchair in her room, as she listened to her book on her tablet. R5 stated she walked 75 feet with therapy.On 08/06/25 at 12:40 PM, Licensed Nurse (LN) I stated the physician would order the laboratory tests, and then the nurse would verify the orders. LN I stated that the lab order would be entered into the laboratory provided system to be obtained as ordered. LN I stated the results would be printed and reviewed by the physician. LN I stated the physician would initial and date the results when reviewed, and signed results would be placed in the folder to be scanned into the resident's EMR.On 08/06/25 at 01:14 PM, Administrative Nurse D stated the physician ordered laboratory orders would be entered into the laboratory provider's system to be obtained as ordered. Administrative Nurse D stated the order would be placed on the Medication Administration Record or the Treatment Administration Record. Administrative Nurse D stated the results should be printed, then reviewed by the physician, and placed in the folder to be scanned into the resident's EMR. Administrative Nurse D stated the lab results should be scanned into the resident's EMR within 24 to 48 hours after being reviewed by the physician. The facility's Laboratory, Radiology, Other Diagnostic Services policy last reviewed 01/2025 documented it was the policy of the facility to obtain laboratory and radiology services when ordered by a Physician, Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) and to promptly notify the ordering provider of test results. Laboratory and radiology services would be arranged as ordered. Results of laboratory, radiological, and diagnostic tests outside the clinical reference ranges would be promptly reported to the resident's attending physician, PA, NP, or CNS, or as specified in the order. Notification of test results would be documented in the resident's clinical record. Results of lab, radiology, and diagnostic services would be made a part of the resident's medical record.- R42's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of venous thrombosis (a clot that develops within a blood vessel), embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream), and dementia (a progressive mental disorder characterized by failing memory and confusion).The admission Minimum Data Set (MDS) dated 07/23/25 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition.R42's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 07/28/25 documented she had a decline in activities of daily living and required an increase in staff assistance. R42's Care Plan, last revised on 08/.04/25 documented labs would be obtained as ordered by the physician. The plan of care documented the staff would report any abnormal lab results to the physician. The plan of care documented the nursing staff would obtain R42's international normalized ratio (INR) (laboratory blood test to check for blood clotting time) on Monday and Thursday.R42's EMR under the Orders tab revealed the following physician orders:Warfarin sodium (anticoagulant - a class of medications used to prevent the blood

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	175558	A. Building B. Wing	08/06/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility identified a census of 64 residents. The facility had one kitchen and two kitchenettes. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to a dirty top of the convection oven with a water bucket on the floor with dripping water, no hairnets worn, and improper food storage. This deficient practice placed the residents at risk for food-borne illness.Findings included:- During the initial tour on 08/04/25 at 07:14 AM, observation revealed the following:Dietary staff CC and dietary staff DD were not wearing hairnets in the kitchen.In the walk-in refrigerator, there was a steam table pan with hot dogs, hamburgers, a bowl with cut-up watermelon, a bowl of lettuce, and a steam table pan with corn salad that were not labeled and were undated. The foods were covered with cling wrap. The dishwasher had documented temperatures on 08/04/25 in the dishwasher temperature monitoring notebook for August. The top of the convection oven had dirt, black gloves, and pan cover sheets that were dirty. The convection oven had a white plastic bucket catching dirty water placed on the floor. The walk-in freezer had French-fried potatoes in a canister that were unlabeled and undated. On 08/04/25 at 08:46 AM, Dietary Staff BB stated all foods should be dated and labeled. He stated that a pipe had broken and was being fixed over the convection oven. Dietary Staff BB stated he was training a new employee who had worked over the weekend, and he would be working with the new employee to ensure the kitchen was kept clean. He stated he would have the kitchen cleaned for the recheck of the kitchen.The facility did not provide a policy for foodborne illness or food storage.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 64 residents. The sample included 15 residents, with two residents reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R) 13. This placed the resident at risk for inappropriate end-of-life care. Findings included:- R13's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue, and severe sleep disturbance), hypertension (high blood pressure), peripheral vascular disease (a circulatory disorder where narrowed or blocked blood vessels reduce blood flow to the limbs, often affection the arms, hands, legs, and feet), major depressive disorder (major mood disorder that causes persistent feelings of sadness), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), muscle weakness, senile degeneration of the brain (age-related cognitive decline, including memory loss and other thinking problems), muscle weakness, need for assistance with personal care. The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R13 needed set-up or cleanup for oral hygiene, supervision or touching assistance for toileting, and partial to moderate assistance for bathing. The MDS documented R13 was dependent on staff for toileting, bathing, and dressing, and was independent with eating. R13's The Functional Activities (Self-Care Mobility) Care Area Assessment (CAA) dated 06/12/25 documented R13 had a reduction in activities of daily living (ADL); she needs increased staff assistance with ADLs, including transfers, bed mobility, toileting, and hygiene. R13 had risk factors included further ADL decline, falls, incontinence, skin breakdown, and pain. R13's Care Plan dated 06/27/25 documented R13 was admitted to hospice, with staff to maintain R13's comfort. The plan of care documented dignity and autonomy would be maintained. The plan of care documented staff were to encourage R13 to express feelings, listen with non-judgmental acceptance, and compassion. The plan of care documented staff were to keep R13's environment quiet and calm and observe R13 closely for signs of pain; nursing was to administer pain medications as ordered and notify the physician immediately if there is breakthrough pain. The plan of care for R13 documented hospice services would supply her supplies as needed. A review of the hospice-provided communication binder revealed R13 was admitted to hospice services on 06/12/25. On 08/04/25 at 10:14 AM, R13 sat in her chair doing crossword puzzles in her room.On 08/05/25 at 09:50 AM, R13 sat on her bed with her elbows leaning on her bedside table.On 08/06/25 at 12:14 PM, Certified Nursing Aide (CNA) M stated nursing had a notebook at the nurse's station with sheets that were printed every day, which told the CNA's pertinent information about each resident. CNA M stated the hospice providers communicated with the nursing staff, and they know when they are giving showers and what supplies they have brought to the resident. CNA M stated she could also look in the notebook provided by the hospice supplier. She stated she did not think hospice information was in the facility's care plan. On 08/06/25 at 12:39 PM, Licensed Nurse (LN) I stated she communicates with the hospice service provider, which was how she knew when hospice aides would be coming to the building. She stated she could also look in the hospice binder kept at the nurse's station. LN I stated she did not think supplies and when hospice staff would be in the building were in the facility care plan. She stated she thought the care plans should match. On 08/06/25 at 01:13 PM, the Administrator Nurse D stated the facility had good communication with nursing and the CNAs. She stated the nursing staff would know when the hospice provider would be in the building and what supplies the hospice provider brings to the facility through communication and the hospice binder kept at the nurse's desk. She stated there should be collaboration of care, and the care plans for the facility and the care plan provided by hospice should match. The facility's Quality of Care policy dated 07/19 documented it was the policy of the facility to provide end-of-life care for dying residents that emphasizes prevention and relief of symptoms as well as compassionate attention to the resident's dignity and preferences. Through continuing interdisciplinary assessment, individualized plans would be developed and implemented to address the resident's physical, intellectual, emotional, social, spiritual, and practical needs. Support and reassurance for the family and friends close to the resident would be an integral part of the plan

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility identified a census of 64 residents. The facility identified 14 residents on Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to store linens in a sanitary manner, the facility further failed to ensure dirty linens were not placed on the floor, and the facility further failed to ensure a barrier was placed on the countertop, before Accu-check (blood glucose monitoring test) monitor was laid on counter. The facility additionally failed to store Resident (R) 3 and R42's respiratory equipment in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Findings included: - On 08/04/25 at 07:05 AM, a walkthrough of the facility was completed.On 08/04/25 at 07:28 AM, towels, washcloths, and a bed sheet were laid on top of R42's Personal Protective Equipment (PPE) cart in the hallway. On 08/04/25 at 01:18 PM, R3 sat in his room talking on his phone. R3's nebulizer mask laid on his bedside table. R3's nebulizer mask was not stored in a sanitary manner.On 08/05/25 at 11:25 AM, soiled linen was on the floor of R75's room.On 08/05/25 at 11:32 AM, Licensed Nurse (LN) I removed the blood glucose machine from the medication cart and placed the machine directly onto the medication cart. LN G picked the machine from the medication cart, then walked into the shower room and placed the machine directly onto the counter by the sink. LN G donned gloves picked the glucose machine from the counter and then placed the machine onto the arm of an empty Broda chair (specialized wheelchair with the ability to tilt and recline). LN G then picked the glucose machine from the arm of the Broda chair, obtained the blood sugar, and then placed the glucose machine directly onto the medication cart and the Accu-Chek monitor should always have a barrier placed.On 08/05/25 at 12:28 PM, R42's nasal oxygen tubing laid on top of her cannister in her room. The nasal cannula was thrown on top of the canister and was at the bottom of R42's bed. On 08/06/25 at 12:14 PM, Certified Nurse's Aide (CNA) M stated all oxygen tubing and nebulizer mask equipment should be stored in a clean plastic bag to prevent contamination and respiratory infections. She stated clean linens should not be placed outside a resident's room, and dirty laundry should never be left on a resident's floor.On 08/06/25 at 12:39 PM, Licensed Nurse (LN) I stated nurses should always place a barrier before setting down an Accu-Check machine. She stated oxygen therapy tubing and nebulizer mask should be placed in a dated plastic bag, due to contamination. LN I stated clean linens should not be placed on a resident's PPE cart. She stated linens should be taken into the residents' rooms. LN I stated dirty laundry should be bagged and taken out of the resident's room and never laid on the resident's floor.On 08/06/25 at 01:13 PM, Administrative Nurse D stated that Accu-Check machines should have a clean barrier placed before setting the machine down. She stated nasal cannulas and nebulizer masks should be placed in a dated plastic bag when not in use. Administrative Nurse D stated that clean linens should not be placed on a PPE cart, and dirty linens should never be laid on a resident's floor.The facility's Infection Control policy dated 03/24 documented it was the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. In long-term care, it was appropriate to make idealized decisions regarding resident placement, balancing infection risks with the need for more than one occupant in the room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 64 residents. The sample included 16 residents, with five residents reviewed for immunization status. Based on record reviews and interviews, the facility failed to obtain consent or declinations for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections), pneumococcal (type of bacterial infection) vaccination for Resident (R) 12 and R75. This placed the residents at increased risk for complications related to pneumonia.Findings included:- Review of R12's clinical record revealed a declination for PCV13 and PPSV23. The clinical record lacked documentation the PCV20 was offered or declined, and lacked documentation of a historical administration. Review of R75's clinical record revealed the PPSV23 was administered on 09/14/18, and PCV13 was administered on 09/13/19. R75's clinical record lacked documentation the PCV20 was offered or declined, and lacked documentation of a historical administration. On 08/06/25 at 01:13 AM, Administrative Nurse D stated she was unsure what immunizations were offered. She stated she was not sure if the facility offered the PCV20. The facility did not provide a policy for immunizations.